STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395587	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadows Nursing and Rehabilitation Center	4 East Center Street Dallas, PA 18612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, a review of clinical records, documentation provided by the facility, and staff interviews, it was determined the facility failed to provide care in a manner that promotes each resident's dignity for one out of 28 residents sampled (Resident 83).Findings include:A clinical record review revealed Resident 83 was admitted to the facility on [DATE], with diagnoses to include peripheral vascular disease (a condition in which narrowed arteries reduce blood flow to the arms or legs). During an observation conducted on July 29, 2025, at 9:48 AM, Employee 10, Nurse Aide (NA), was seen transporting Resident 83 in a white shower chair through the third-floor 300s unit hallway in route to the shower room. Resident 83 was wearing only a black t-shirt that extended to his waist and was not wearing pants. A white cloth was loosely draped across the resident's lap. Resident 83's buttocks and approximately four inches of his gluteal cleft (the groove between the buttocks) were visibly exposed as he was pushed in the chair through the hallway and into the shower room. An employee statement dated July 29, 2025, revealed Employee 10, nurse aide (NA), was unaware that Resident 83's backside was exposed during the transport. The employee stated, In the future, I will use two bath towels to ensure all areas are covered. During an interview on July 29, 2025, at approximately 1:00 PM, the Nursing Home Administrator (NHA) confirmed that residents have the right to be provided care with dignity. The NHA indicated that Resident 83 should have been properly covered and should have been provided with appropriate clothing to ensure that his backside was not exposed while being transported through a public hallway. The facility failed to ensure that Resident 83 received care in a manner that maintained his dignity.28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.12 (c)(d)(1) Nursing services.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and staff interviews, it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a clean, safe, orderly and sanitary resident environment in the room of one of 28 residents reviewed. (Resident 2) Findings include: Observations of Resident 2's room on the [NAME] unit, on July 29, 2025, at 1036 AM, revealed a fitted bed sheet with an approximately 6-inch x6-inch tan stain noted to be on the left side middle portion of the fitted sheet.An observation to Resident 2's room on July 30, 2025, at 10:47 AM revealed the fitted bed sheet noted an approximately 6 -inch by 6 -inch tan stain noted to be on the left side middle portion of the bed. Further observation revealed a 7- inch by 6-inch tan stain noted on the lower right side of the fitted sheet. Additionally, noted to be at the foot of fitted sheet were 4 8-inch streaks of a dark red substance running along the foot of the fitted sheet.An observation made in Resident 2's room on July 30,2025 at 1:00 P.M. revealed the fitted bed sheet noted an approximately 6- inch by 6- inch tan stain noted to be on the left side middle portion of the bed. Further observation revealed a 7 -inch by 6-inch tan stain noted on the lower right side of the fitted sheet. Additionally, noted to be at the foot of fitted sheet were approximately 4 8-inch-long streaks of a dark red substance running along the foot of the fitted sheet.An interview with Employee 4, Nurse Aide NA on July 30, 2025, confirmed the sheets were visibly soiled. During the interview Employee 4 revealed bedding is usually changed on shower days or when visibly soiled. Employee 4 revealed that he was responsible for Resident 2's care during the day shift of July 30th,2025 but did not realize the sheets were soiled. An interview with the Director of Nursing (DON) was conducted on July 30, 2025, at 2:15 PM, to review the above observations and confirmed that the facility failed to maintain a safe, sanitary and orderly environment in Resident 2's room. 28 Pa. Code 201.18 (e)(1) (2.1) Management. 28 Pa. Code 201.14 (a) Responsibility of licensee.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility-initiated transfer notices, and staff interviews, it was determined the facility failed to provide copies of written notice of facility-initiated hospital transfers of residents to a representative of the Office of the State Ombudsman for 2 out of 28 residents reviewed (Residents 41 and 70).Findings include: A review of the clinical record revealed that Resident 41 was transferred to the hospital on May 13, 2025, and was readmitted to the facility on [DATE]. A review of the clinical record revealed that Resident 70 was transferred to the hospital on April 28, 2025, and was readmitted to the facility on [DATE]. Although written notices were provided to the resident and resident representative of the facility-initiated transfer, there was no documented evidence the facility sent copies of written notices of these facility-initiated transfers to the representative of the Office of the State Long-Term Care Ombudsman. An interview with the Nursing Home Administrator on July 31, 2025, at approximately 12:00 P.M., confirmed there was no documented evidence that copies of facility-initiated transfer notices for Residents 41 and 70 were sent to a representative of the Office of the State Long-Term Care Ombudsman. 28 Pa. Code 201.14(a) Responsibility of licensee.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and staff interviews, it was determined the facility failed to fully develop and revise a person-centered comprehensive care plan to meet the individualized needs of two residents out of 28 sampled (Resident 7 and 41).Findings included: A review of Resident 7's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included congestive heart failure (a condition in which the heart doesn't pump blood as well as it should) and diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin (a hormone that helps regulate blood sugar levels) or when the body cannot effectively use the insulin it produces). A review of a quarterly Minimum Data Set assessment (MDS a federally mandated standardized assessment process conducted periodically to plan resident care) dated July 11, 2025, revealed that Resident 7 is cognitively intact with a BIMS score of 13 (Brief Interview for Mental Status a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). A clinical record review for Resident 7 revealed physician's orders, dated January 3, 2025, for Lispro (short-acting insulin) four times a day subcutaneously (injection under the skin) with a sliding scale insulin coverage (a method used to manage blood sugar levels by giving insulin based on blood sugar readings) dependent on his blood glucose level and Lantus (long-acting insulin), dated January 2, 2025, subcutaneously 20 units in the morning and 20 units at bedtime. Further review for Resident 7 revealed a physician's order dated January 4, 2025, for a daily 1500 milliliter (ml) fluid restriction (360 ml allotted for breakfast, 300 ml allotted for lunch, and 300 ml allotted for dinner) and 540 ml allotted for nursing fluids (180 ml during the 7:00 AM to 3:00 PM shift, 180 ml during the 3:00 PM to 11:00 PM shift, and 180 ml during the 11:00 PM to 7:00 AM shift). A review of the resident's comprehensive plan of care, last revised on January 6, 2025, failed to reflect these updated medical treatments and interventions. A review of Resident 41's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included hypertension (blood pressure that is higher than normal) and hypoxemia (a low level of oxygen in the blood). A review of a quarterly MDS dated [DATE], revealed that Resident 41 was cognitively intact with a BIMS score of 12 (a score of 13-15 indicates cognition is intact). A clinical record review for Resident 41 revealed physician's orders, dated May 31, 2024, for oxygen 2 L/minute via nasal cannula (flexible tube to deliver oxygen by two small prongs in the nose) for shortness of breath. A review of the resident's comprehensive plan of care, last revised on July 7, 2025, failed to reflect these updated medical treatments and interventions. During an interview on July 31, 2025, at approximately 11:00 AM, the Nursing Home Administrator confirmed the facility failed to ensure that comprehensive care plans were fully developed for Resident 7 and Resident 41. 28 Pa. Code 211.12 (d)(5) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record reviews, facility policies, facility investigative documentation, manufacturer instructions, and staff and resident interviews, it was determined the facility failed to implement interventions to prevent the development of a pressure injury for two residents (Residents 58 and 6) and failed to implement physician-ordered pressure-relief measures for two residents (Residents 11 and 70) out of 28 residents reviewed. Findings include: According to the US Department of Health and Human Services, Agency for Healthcare Research & Quality, the best pressure ulcer practice bundle incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, Standardized pressure ulcer risk assessment, and care planning and implementation to address the areas of risk. The American College of Physicians (ACP) is a national organization of internists who specialize in the diagnosis, treatment, and care of adults. Clinical Practice Guidelines indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i.e., support surfaces, repositioning, and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement, and wound cleansing; using adjunctive therapies; and considering possible surgical repair. A review of the facility policy titled Prevention of Pressure Ulcers, last reviewed by the facility on June 30, 2025, revealed it is the facility's policy to ensure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and family, and addressed. The policy indicates general preventive measures include identifying risk factors for pressure ulcer development. Interventions include changing position at least every two hours or more frequently if needed, determining if residents need a special mattress, ensuring the special mattresses contain foam or air as indicated, reducing shear by lifting rather than dragging, referring residents to rehabilitation or restorative nursing programs as indicated, and encouraging residents to participate in active and passive range of motion exercises to improve circulation. When in bed every attempt should be made to float heels (keep heels off the bed) by placing a pillow from knee to ankle or with other devices as recommended by the therapist or prescribed by the physician. A clinical record review revealed Resident 58 was admitted to the facility on [DATE], with diagnoses that included chronic kidney disease (a condition where the kidneys cannot adequately filter waste from the blood) and spinal stenosis (a condition where the spinal column narrows, putting pressure on the spinal cord or the nerves). A review of a quarterly Minimum Data Set assessment (MDS a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 12, 2025, revealed that Resident 58 is cognitively intact with a BIMS score of 14 (Brief Interview for Mental Status a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). The care plan initiated June 16, 2025, identified the resident as being at risk for pressure ulcers due to dehydration and immobility. The physician's orders revised July 18, 2025, included use of a bariatric air mattress with settings adjusted to the resident's most current weight. A wound note dated July 28, 2025, identified a Stage II pressure injury on the sacrum (lower back area) measuring 0.4 cm x 0.4 cm x 0.2 cm, characterized by partial-thickness skin loss and pink wound bed. According to manufacturer guidance an alternating pressure therapy pump overlay/replacement mattress system operating manual provided by the facility revealed the pump display has a low-pressure function indicator. When an abnormally low pressure occurs, the low-pressure indicator (yellow LED) will light up. Check that the connections are correctly made and that they are correctly installed as per installation instructions. A note indicated that if the pressure level is consistent, check for any leakage (tubes or connecting hoses). If necessary, replace any damaged tubes or hoses. Despite these orders, an observation on July 29, 2025, at 10:05 AM, revealed the air mattress was set to support a resident weighing 500 pounds. The resident's actual weight as of July 2, 2025, was 235.6 pounds. The air mattress pump displayed a yellow low-pressure warning light. Resident 58 reported the mattress had been uncomfortable for several weeks. A follow-up observation on July 29, 2025, at 10:28 AM revealed Resident 58's air mattress pump continued to indicate low pressure. During an interview on July 29, 2025, at approximately 11:00 AM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed the air mattress pump should be set to match the resident's weight. The DON and NHA indicated the low-pressure indicator light should not continue to be lit. During an interview on July 29, 2025, at 11:25 AM

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of select facility policy, and resident and staff interviews, it was determined the facility failed to consistently provide restorative nursing services as planned to maintain mobility to the extent possible for one resident out of 28 residents sampled (Resident 18).Findings include: A review of the facility policy titled Restorative Nursing Program, last reviewed by the facility on June 30, 2025, revealed it is the facility's policy to provide a restorative nursing program that focuses on achieving and/or maintaining optimal function in accordance with a comprehensive assessment and plan of care. The policy indicated the restorative nurse monitors on an ongoing basis all aspects of the individualized restorative nursing programs offered and oversees documentation by nurse aides. A clinical record review revealed Resident 18 was admitted to the facility on [DATE], with diagnoses to include inflammatory Poly arthropathy (a condition where multiple joints are inflamed). A review of a quarterly Minimum Data Set assessment (MDS a federally mandated standardized assessment process conducted periodically to plan resident care) dated July 4, 2025, revealed that Resident 18 is cognitively intact with a BIMS score of 13 (Brief Interview for Mental Status a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). A review of Resident 18's care plan revealed a restorative nursing walking program initiated on March 24, 2025. Interventions implemented to assist the resident towards a goal of walking in the corridor with the assistance of one person up to 350 feet or to tolerance include restorative training in a walking program with rollator walking (a mobility device) and the assistance of one staff member for distances upwards of 350 ft., initiated on July 7, 2025. During an interview on July 30, 2025, at approximately 10:30 AM, Resident 18 indicated she was upset because she wants to walk every day, but staff do not walk with her. She said in the last month she had only walked one time. Resident 18 explained she has not been asked to walk and would not refuse to walk with staff. A clinical record review revealed an ambulation task for Resident 18's restorative training in the walking/ambulation program. RNP (restorative nursing program) ambulation with RW (rollator walker) and A (assistance) of 1 staff for distances upwards of 350 feet or as tolerated was documented as completed on July 30, 2025, at 10:47 AM. During an interview on July 30, 2025, at 11:45 AM, Resident 18 confirmed no one walked with her this morning. She explained that she was in an interview with the healthcare surveyor at that time. In a subsequent interview on July 30, 2025, at 11:50 AM, Employee 3, Nurse Aide (NA), acknowledged that she documented the RNP ambulation task as completed for Resident 18. Employee 3 further stated that she had not yet performed the ambulation task but had documented it prior, with the intention to provide the service later that afternoon Further clinical record review revealed Resident 18's RNP ambulation task was marked as completed 25 times from July 7, 2025, through July 29, 2025, and marked as the resident refused 19 times during that same period. During an interview on July 30, 2025, at approximately 1:00 PM, the Nursing Home Administrator (NHA) confirmed facility staff should not document plan of care tasks as complete when the care did not occur. The NHA acknowledged that Resident 18 reported not receiving her scheduled ambulation interventions as documented. The NHA was unable to explain the discrepancy between the documentation indicating that the ambulation program was being consistently provided and the resident's statement that she had only been walked once in recent weeks. 28 Pa. Code: 211.5(f)(ix) Medical records. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa Code 211.12(d)(3)(5) Nursing services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of clinical records, facility investigative documentation, and resident and staff interviews, it was determined the facility failed to ensure the residents environment remains free of accident hazards for one out of 28 residents sampled (Resident 92).Findings include: A clinical record review revealed Resident 92 was admitted to the facility on [DATE], with diagnoses that include peripheral vascular disease (condition in which narrowed arteries reduce blood flow to the arms or legs) and neuropathy (a condition in which nerve damage interferes with the functioning of the nervous system). A review of an Annual Minimum Data Set assessment (MDS a federally mandated standardized assessment process conducted periodically to plan resident care) dated June 25, 2025, revealed that Resident 92 was cognitively intact with a BIMS score of 13 (Brief Interview for Mental Status a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). A progress note dated June 20, 2025, at 2:09 PM revealed Employee 1, Registered Nurse (RN), was called to Resident 92's room. Upon assessment, the resident's right foot was noted to have +2 pitting edema (swelling graded on a scale from 0 to 4, based on the depth and duration of the indentation left when pressure is applied to the swollen area) with a 2.0 cm x 2.0 cm bruise located medially on the dorsum of the right foot (the top-side middle of her foot). No open areas or complaints of pain were indicated. Employee 1, RN, described the bruise as light purple in color and circular in shape. The progress note indicated a description of the event by Resident 92: I was getting a shower, and the aide accidentally dropped the showerhead, and it fell on my foot. Documentation confirmed the incident was reported to maintenance and that both the physician and resident representative were notified. Documentation provided by the facility dated June 20, 2025, described that Employee 2, Nurse Aide (NA), accidentally dropped a showerhead onto Resident 92's foot. It further revealed that all shower stalls had broken hooks, preventing the showerheads from being safely secured during care. The staff reportedly placed the showerheads on grab bars, which led to the incident. This was communicated to maintenance. Review of a written witness statement dated June 20, 2025, Employee 2, NA, indicated that she gave Resident 92 a shower and the showerhead fell. She recalled Resident 92 saying something about the showerhead falling, but nothing about Resident 92's foot having pain or the resident complaining about pain at that time. A right foot x-ray ordered on June 23, 2025, was initially inconclusive due to a bandage, prompting a repeat order. The second x-ray on June 24, 2025, revealed an age-indeterminate deformity of the second toe, with no evidence of bone infection. A pain evaluation document dated June 26, 2025, revealed Resident 92 had experienced pain over the last five days related to her right foot. The document indicated the resident also had pain related to chronic arthritis. Resident 92 indicated the pain was an 8 out of 10 (numeric scale to rate pain 00 being the least amount of pain and 10 being the worst). Resident 92 indicated rest, elevation, ice, and acetaminophen reduced her discomfort. A progress note dated June 30, 2025, at 9:34 AM revealed the resident requested the nurse to look at the resident's right foot related to pain and swelling. Upon assessment, the right foot appeared to be swollen, red, warm, tender, and painful to touch. The physician was notified and an order for the antibiotic cephalexin 500 mg twice daily for 10 days was initiated for cellulitis (a potentially serious skin infection that occurs when bacteria enter broken skin. It causes redness, warmth, swelling, and pain, and typically requires antibiotics for treatment.). A physician progress note dated July 2, 2025, documented a diagnosis of cellulitis of the right foot secondary to trauma from the showerhead. The resident's pain and swelling were reported to be improving with antibiotic treatment. Cephalexin was administered as ordered through July 10, 2025. A podiatry consultation form dated July 9, 2025, revealed Resident 92 had pain, edema (fluid buildup), and fluctuance (boggy sensation felt on touch) on the right distal foot (top side of the foot). The consultation indicated concern with hematoma/fluid buildup in the right foot. The resident had cellulitis resolved with antibiotic therapy. Recommend magnetic resonance imaging (MRI medical test that uses strong magnet and radio waves to create detailed pictures of the inside of the body) without contrast. The resident may need incision and drainage of the right foot. Discussed with nursing. On July 11, 2025, the resident was scheduled for an MRI to occur on August 6, 2025. However, on July 17, 2025, the resident declined the MRI and an order for an ultrasound was obtained instead. A soft tissue ultrasound conducted that same day identified a moderately complex hematoma/seroma (a buildup of fluid) on the top of the right foot resulting from the trauma. A